NATIONAL HEALTH INSURANCE COMPANY

PO Box 1070, Winston-Salem, NC 27102-1070

OUTLINE OF COVERAGE

Benefit Plans A, F, High Deductible F, G and N

Benefit Charge of Medicare Supplement Plans Sold on or after January 1, 2022

NOTICE TO BUYER: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. They buyer is advised to review carefully all policy limitations.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only+	
	A♦	B	D	G1♦	K	L	M	N♦	C	F♦1
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					$7060[2]	$3530[2]				

Note: A ✓ means 100% of the benefit is paid. +**Only applicants first eligible for Medicare before January 1, 2010 may purchase Plans C, F, and high deductible F.** This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Every company must make Plan A available.

1 - Plans F and G also have a high deductible option which require first paying a plan deductible of $2800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plans F and G do not cover the separate Foreign travel emergency deductible. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 - Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 - Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

◆ Plans currently being offered

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan A
Issue Age Premium Rates
Rates Effective Upon Approval

Issue	Female		Male	
Age	Preferred	Standard	Preferred	Standard
0-64	377.68	434.26	434.26	499.07
65	113.30	130.28	130.28	149.71
66	113.30	130.28	130.28	149.71
67	116.85	134.35	134.35	154.39
68	120.85	138.80	138.80	159.58
69	123.51	141.98	141.98	163.11
70	126.25	145.17	145.17	166.83
71	128.99	148.17	148.17	170.36
72	131.73	151.44	151.44	174.08
73	135.09	155.33	155.33	178.50
74	138.45	159.22	159.22	183.09
75	141.98	163.20	163.20	187.60
76	145.61	167.45	167.45	192.47
77	149.32	171.69	171.69	197.33
78	151.44	174.08	174.08	200.07
79	153.57	176.46	176.46	202.72
80	155.60	178.85	178.85	205.55
81	157.72	181.24	181.24	208.38
82	159.67	183.62	183.62	211.03
83	164.17	188.75	188.75	216.95
84	168.60	193.79	193.79	222.88
85	172.93	198.92	198.92	228.45
86	177.26	203.78	203.78	234.28
87	181.50	208.64	208.64	239.85
88	185.83	213.59	213.59	245.51
89	190.26	218.63	218.63	251.35
90	194.76	223.85	223.85	257.36
91	199.45	229.24	229.24	263.55
92	204.14	234.64	234.64	269.73
93	209.00	240.29	240.29	276.01
94	213.95	245.95	245.95	282.64
95	218.99	251.79	251.79	289.27
96	224.20	257.62	257.62	296.17
97	229.51	263.81	263.81	303.24
98	234.90	270.00	270.00	310.40
99+	240.56	276.45	276.45	317.74

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate
A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.97 if discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C

Quarterly, Semi-Annual, or Annual Rate
G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
H - Calculate Final Modal Billing Rate (rounded to the nearest penny) H=F*G

Household Discount: 3%

The rates above do not include a one time $25 policy fee.

Area Factors:

Florida Zip Codes	Factor
Area 1: 330-334	1.980
Area 2: 322-322, 335-337, 346, 349	1.410
Area 3: All Other Zip Codes	1.350

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan F
Issue Age Premium Rates
Rates Effective Upon Approval

Issue	Female		Male	
Age	Preferred	Standard	Preferred	Standard
0-64	524.53	603.12	603.12	693.12
65	157.35	180.95	180.95	207.94
66	157.35	180.95	180.95	207.94
67	162.27	186.60	186.60	214.44
68	167.80	192.82	192.82	221.64
69	171.51	197.15	197.15	226.59
70	175.31	201.66	201.66	231.72
71	179.12	205.90	205.90	236.58
72	183.01	210.24	210.24	241.71
73	187.60	215.72	215.72	247.90
74	192.38	221.11	221.11	254.26
75	197.24	226.68	226.68	260.54
76	202.28	232.51	232.51	267.26
77	207.32	238.44	238.44	273.98
78	210.24	241.71	241.71	277.87
79	213.24	245.07	245.07	281.67
80	216.07	248.43	248.43	285.56
81	218.99	251.79	251.79	289.36
82	221.91	255.06	255.06	293.16
83	228.09	262.22	262.22	301.38
84	234.19	269.20	269.20	309.52
85	240.29	276.19	276.19	317.39
86	246.22	283.00	283.00	325.43
87	252.14	289.80	289.80	333.12
88	258.06	296.70	296.70	340.99
89	264.25	303.68	303.68	349.12
90	270.53	310.93	310.93	357.35
91	276.90	318.45	318.45	365.92
92	283.53	325.96	325.96	374.67
93	290.24	333.65	333.65	383.43
94	297.14	341.61	341.61	392.62
95	304.13	349.66	349.66	401.82
96	311.29	357.88	357.88	411.28
97	318.71	366.36	366.36	421.09
98	326.23	375.03	375.03	431.17
99+	334.01	383.96	383.96	441.33

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate
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Quarterly, Semi-Annual, or Annual Rate
G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
H - Calculate Final Modal Billing Rate (rounded to the nearest penny) H=F*G

Household Discount: 3%

The rates above do not include a one time $25 policy fee.

Area Factors:

Florida Zip Codes	Factor
Area 1: 330-334	1.980
Area 2: 322-322, 335-337, 346, 349	1.410
Area 3: All Other Zip Codes	1.350

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Issue Age Premium Rates
Rates Effective Upon Approval

Issue	Female		Male	
Age	Preferred	Standard	Preferred	Standard
0-64	209.88	241.36	241.36	277.25
65	62.98	72.40	72.40	83.17
66	62.98	72.40	72.40	83.17
67	64.94	74.66	74.66	85.77
68	67.10	77.18	77.18	88.67
69	68.61	78.86	78.86	90.62
70	70.20	80.63	80.63	92.65
71	71.61	82.40	82.40	94.60
72	73.20	84.17	84.17	96.72
73	75.06	86.29	86.29	99.11
74	76.92	88.41	88.41	101.67
75	78.86	90.62	90.62	104.23
76	80.89	93.01	93.01	106.97
77	82.93	95.30	95.30	109.63
78	84.17	96.72	96.72	111.13
79	85.31	98.05	98.05	112.63
80	86.46	99.37	99.37	114.22
81	87.61	100.70	100.70	115.73
82	88.76	102.02	102.02	117.23
83	91.24	104.94	104.94	120.50
84	93.71	107.68	107.68	123.77
85	96.10	110.51	110.51	126.95
86	98.49	113.16	113.16	130.23
87	100.87	115.90	115.90	133.23
88	103.26	118.73	118.73	136.41
89	105.74	121.47	121.47	139.69
90	108.21	124.39	124.39	142.96
91	110.78	127.31	127.31	146.40
92	113.43	130.40	130.40	149.85
93	116.17	133.50	133.50	153.39
94	118.91	136.59	136.59	157.01
95	121.65	139.86	139.86	160.73
96	124.48	143.13	143.13	164.53
97	127.40	146.58	146.58	168.42
98	130.49	150.03	150.03	172.49
99+	133.59	153.57	153.57	176.55

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Household Discount: 3%

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Area 1: 330-334	1.980
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NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan G
Issue Age Premium Rates
Rates Effective Upon Approval

Issue	Female		Male	
Age	Preferred	Standard	Preferred	Standard
0-64	472.19	542.92	542.92	623.81
65	141.65	162.87	162.87	187.14
66	141.65	162.87	162.87	187.14
67	146.08	167.96	167.96	192.99
68	151.09	173.46	173.46	199.54
69	154.36	177.44	177.44	203.96
70	157.81	181.50	181.50	208.56
71	161.17	185.30	185.30	212.98
72	164.71	189.19	189.19	217.57
73	168.77	194.06	194.06	223.05
74	173.10	199.10	199.10	228.89
75	177.52	204.05	204.05	234.55
76	182.03	209.26	209.26	240.56
77	186.63	214.57	214.57	246.57
78	189.19	217.57	217.57	250.11
79	191.85	220.58	220.58	253.47
80	194.50	223.59	223.59	257.00
81	197.15	226.59	226.59	260.36
82	199.71	229.60	229.60	263.81
83	205.28	236.05	236.05	271.24
84	210.77	242.24	242.24	278.49
85	216.25	248.60	248.60	285.65
86	221.55	254.70	254.70	292.81
87	226.94	260.81	260.81	299.79
88	232.25	266.99	266.99	306.95
89	237.82	273.36	273.36	314.20
90	243.48	279.90	279.90	321.63
91	249.22	286.62	286.62	329.32
92	255.24	293.43	293.43	337.28
93	261.25	300.32	300.32	345.06
94	267.44	307.48	307.48	353.37
95	273.71	314.73	314.73	361.59
96	280.17	322.07	322.07	370.17
97	286.80	329.76	329.76	379.01
98	293.60	337.54	337.54	388.02
99+	300.68	345.50	345.50	397.22

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NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N
Issue Age Premium Rates
Rates Effective Upon Approval

Issue	Female		Male	
Age	Preferred	Standard	Preferred	Standard
0-64	358.88	413.10	413.10	474.58
65	107.66	123.93	123.93	142.36
66	107.66	123.93	123.93	142.36
67	111.03	127.80	127.80	146.81
68	114.89	132.00	132.00	151.69
69	117.39	134.90	134.90	155.07
70	119.98	138.05	138.05	158.62
71	122.56	140.87	140.87	161.93
72	125.30	143.94	143.94	165.48
73	128.37	147.65	147.65	169.68
74	131.68	151.36	151.36	174.03
75	134.98	155.15	155.15	178.39
76	138.45	159.19	159.19	182.91
77	141.92	163.22	163.22	187.51
78	143.94	165.48	165.48	190.25
79	145.96	167.74	167.74	192.75
80	147.97	170.08	170.08	195.50
81	149.91	172.34	172.34	198.00
82	151.85	174.60	174.60	200.66
83	156.12	179.52	179.52	206.31
84	160.24	184.28	184.28	211.87
85	164.43	189.04	189.04	217.28
86	168.55	193.72	193.72	222.69
87	172.58	198.40	198.40	228.01
88	176.62	203.08	203.08	233.42
89	180.89	207.84	207.84	238.98
90	185.17	212.84	212.84	244.63
91	189.53	217.93	217.93	250.44
92	194.12	223.09	223.09	256.41
93	198.72	228.41	228.41	262.46
94	203.40	233.74	233.74	268.76
95	208.16	239.31	239.31	275.05
96	213.17	244.96	244.96	281.50
97	218.17	250.84	250.84	288.20
98	223.25	256.65	256.65	295.14
99+	228.66	262.79	262.79	302.08

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BASIC BENEFITS

Hospitalization –Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses –Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood –First three pints of blood each year.
Hospice— Part A coinsurance.

PREMIUM INFORMATION

We, National Health Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

IF YOU FIND THAT YOU ARE NOT SATISFIED WITH YOUR POLICY, YOU MAY RETURN IT TO: PO BOX 1070, WINSTON-SALEM, NC 27102-1070. IF YOU SEND THE POLICY BACK TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, WE WILL TREAT THE POLICY AS IF IT HAD NEVER BEEN ISSUED, AND RETURN ALL OF YOUR PAYMENTS.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither National Health Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage your local Social Security Office or consult *Medicare and You* for more details. Use the outline to compare benefits and premiums among policies.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, and it is **NOT** an "Open Enrollment or Guaranteed Issue status application," be sure to answer truthfully and completely all questions about your medical and health history. The policy is issued on the basis that the answers to all questions and all information shown in the application are correct and complete. The company may cancel your policy and refuse to pay any claims if you make misstatements, leave out or falsify important information. Review the application carefully before you sign it. Be certain that all information has been properly recorded. To review "Open Enrollment" timeframes please go to the following link on the Medicare.gov website:
https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

NATIONAL HEALTH INSURANCE COMPANY

PO Box 1070, Winston-Salem, NC 27102-1070

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skill care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITILIZATION* Semiprivate room and board, general nursing and miscellaneous services and Supplies			
First 60 days	All but $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
---Once lifetime reserves days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**Notice When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***** Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F OR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITILIZATION*			
Semiprivate room and board, general Nursing and miscellaneous services and Supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
---Once lifetime reserves days are used:			
---Additional 365 days	$0	% of Medicare eligible expenses	$0***
---Beyond 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+ Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, or high deductible F.

PLAN F OR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$100	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

+ Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, or high deductible F.

PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

+ Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, or high deductible F.

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skill care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITILIZATION* Semiprivate room and board, general Nursing and miscellaneous services and Supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
---Once lifetime reserves days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**Notice When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skill care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITILIZATION* Semiprivate room and board, general Nursing and miscellaneous services and Supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
---Once lifetime reserves days are used:			
---Additional 365 days	$0	% of Medicare eligible expenses	$0**
---Beyond 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**Notice When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N
MEDICARE (PART B) - HOSPITAL SERVICES - PER CALENDAR YEAR

***** Once you have been billed $240 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office and visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum